City of Mountain Park

AUTHORIZATION TO TREAT A MINOR

I/We, the undersigned, parent (s) or legal guardian of _____ a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis, treatment or procedures and hospital care which is deemed advisable by, and is suggested, recommended, prescribed or directed by any physician or surgeon duly licensed to practice in the State of Georgia.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatments will not be withheld if the undersigned cannot be reached.

This authorization shall remain in effect until October 1, 20____, unless sooner revoked in writing delivered to said agent (s).

CHILD'S NAME_____
ADDRESS_____CITY_____
BIRTHDATE_____ AGE_____LAST YEAR IN SCHOOL_____
SCHOOL ATTENDED_____

LAST TETANUS/DIPHTHERIA BOOSTER:_____
ALLERGIES TO DRUGS, FOOD, OTHERS:_____
_____
ANY SPECIAL MEDICATION OR PERTINENT INFORMATION:_____
_____
_____
FAMILY PHYSICIAN:_____
PHONE:_____

TELEPHONE NUMBERS WHERE PARENTS OR GUARDIAN MAY BE REACHED:

HOME PHONE NUMBER_____

MOTHER'S NAME_____WORK #_____
PAGER#_____
FATHER'S NAME_____WORK#_____
PAGER_____
LEGAL GUARDIAN_____WORK#_____
PAGER#_____

Date:_____ AUTHORIZATION_____
Witness:_____ Signature of Parent or Legal Guardian